**EPSDT Health Services**

**CHECKLIST OF FORMS TO BE SUBMITTED**

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an EPSDT Health Services provider:

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| --- | --- |
| Completed | Document Name |
| \* | 1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form. |
| \* | 1. Completed PE-50 Addendum – Provider Agreement Form (two pages). |
| \* | 1. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form. |
| \* | 1. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. **(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)**   **Option 1** (preferred): Provider Ownership Enrollment Web Application. Go to [www.lamedicaid.com](http://www.lamedicaid.com) and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.  **-or-**  **Option 2** (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. |
| \* | 1. **(If submitting claims electronically)**  Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable). |
| \* | 1. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**). |
| \* | 1. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**). |
|  | 1. To report “Specialty” for this provider type on Section A of the PE-50 in the Basic Enrollment Packet, please use Code 44 (Public Health). |
| \*\* | 1. **Only For Charter Schools:** Completed Declaration of Charter School Status Form. |
| \*\* | 1. Completed PE-50 EPSDT Health Services For Children With Disabilities Provider Enrollment Supplement Agreement |
| \*\* | 1. Completed PE-50 EPSDT Provider Supplement Agreement B. |
| \*\* | 1. Completed PE-50 EPSDT Provider Supplement Agreement C - School Board/Charter School Certification of Understanding **(if applicable)** |
|  | 1. Printout of online medical license verification from the governing license board for each therapist identified in the list specified in item 13 above. This verification must contain the license number, the effective date of issuance, and the current status of the license. |
| \*\* | 1. Completed Individual Therapist Form. |
|  | 1. Copy of the Early Intervention license from the Department of Social Services for providers serving the 0 to 3 year old population |
|  | 1. **Only for Parish School Board/Charter Schools:** Completed Amendment to the Provider Agreement Between DHH-BHSF and the appropriate Parish School Board/Charter School (4 pages). |

\* Forms are included in the Basic Enrollment Packet

\*\* Forms are included here

***PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS) – DO NOT SUBMIT COPIES OF THE ATTACHED FORMS.***

Please submit all required documentation to:

**Molina Medicaid Solutions Provider Enrollment Unit**

**PO Box 80159**

**Baton Rouge, LA 70898-0159**

PE-50 EPSDT HEALTH SERVICES FOR CHILDREN WITH DISABILITIES PROVIDER ENROLLMENT SUPPLEMENT AGREEMENT

In order to facilitate your enrollment as an EPSDT Health Services provider in Medicaid of Louisiana, you must provide the information that is requested below.

Name of Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Provider Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Mailing and Street):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and Telephone Number if Other Sites (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Check the EPSDT health service(s) you wish to provide, list any restrictions related to the age or the number of children, geographical areas, or other factors, or enter “none.” Attach documentation of applicable licensing and certification for staff providing these services.

SERVICE RESTRICTIONS

\_\_\_\_\_\_\_\_\_\_\_Audiologic Evaluation

\_\_\_\_\_\_\_\_\_\_\_Speech and Language Evaluation

\_\_\_\_\_\_\_\_\_\_\_Speech, Language or Hearing Therapy

\_\_\_\_\_\_\_\_\_\_\_Occupational Therapy Evaluation

\_\_\_\_\_\_\_\_\_\_\_Occupational Therapy

\_\_\_\_\_\_\_\_\_\_\_Physical Therapy Evaluation

\_\_\_\_\_\_\_\_\_\_\_Physical Therapy

\_\_\_\_\_\_\_\_\_\_\_Behavioral Health Services

\_\_\_\_\_\_\_\_\_\_\_Applied Behavior Analyst

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* All services must be provided as part of or in the interest of establishing an Individual Service Plan (ISP) or an individual Family Service Plan (IFSP).

The Agreement, made by and between Medicaid of Louisiana and \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Provider), sets forth the terms of participation in Early Periodic Screening and Diagnostic Treatment (EPSDT) health services to children with disabilities. The parties, intending to be legally bound, agree as follows.

1. The provider agrees to adhere to all general enrollment conditions of Medicaid of Louisiana.

2. The provider agrees to comply with all applicable program requirements for services, timeliness

standards, and reasonable standards of medical and other health professional practices set forth in the EPSDT Health Services Provider Manual.

3. The provider agrees to maintain sufficient staff, facilities, equipment, and supplies to provide

the agreed upon services and notify Medicaid of Louisiana promptly, in writing, whenever

he/she is not longer able to provide the services.

4. The provider agrees to ensure that recipients are allowed to choose providers freely.

5. The provider agrees to establish procedures through which eligible recipients and families may

present grievances which may arise from EPSDT services provided under this agreement.

6. The provider agrees that the submission by or on behalf of the provider of any claim shall be

certification that the specific services for which the payment is claimed were provided to the person identified as the recipient.

7. The provider agrees to keep records necessary to disclose the extent of EPSDT services

provided to recipient for five years from the date of payment, to provide this information, as

requested, to Medicaid of Louisiana or its authorized representative, and to cooperate with on-

site reviews, and other monitoring and training activities.

8. The provider agrees to use Medicaid funds received for these services solely for the provision

and/or enhancement of health services to children. These Medicaid funds may be used for the

direct provision of these services and to defray the administrative cost of providing these

services.

9. The provider agrees to submit claims within 1 year of the date of service and to submit these

claims electronically.

10. The provider agrees to participate in KIDMED recipient outreach activities, including identifying

and informing recipients of the benefits of preventive care, and how to access KIDMED

screening services.

11. The provider agrees to provide age appropriate KIDMED medical, vision, and hearing screening services to Medicaid recipients under the age of 21 who are receiving EPSDT health services reimbursed by Medicaid or to contact KIDMED immediately to arrange for these screening services.

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12. The provider agrees to refer any suspected child abuse, neglect, and/or sexual abuse of

recipients under the age of 21 promptly to the Office of Community Services in the parish

where the recipient resides.

13. Medicaid of Louisiana agrees to reimburse the provider for EPSDT health services covered by

Medicaid in accordance with applicable regulations and the schedule of maximum Medicaid fees

for these services.

14. The effective date of this agreement shall be the date on which it is signed by Medicaid of

Louisiana unless otherwise stated.

15. This agreement may be terminated by either party upon 30 days after the receipt of a written

notice by the other party.

I certify that the information provided on this form is true to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider-Authorized Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Director or Designee Date

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**Individual Therapist Form (Applied Behavior Analyst)**

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| --- | --- |
| Please Print Name of EPSDT Health Services: |  |

**List all individuals that are providing the therapy services identified on the PE-50 EPSDT Health Services for Children with Disabilities Provider Enrollment Supplement Agreement form (i.e., Audiology, Speech and Language, Occupational Therapy, Physical Therapy, Behavioral Health Services and/or Applied Behavior Analyst. Attach a copy of a current license for each.**

|  |  |  |
| --- | --- | --- |
| Therapist Name | Therapist Specialty | Therapist License Number |
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Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Representative Date of Signature

Print Name of Authorized Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 10/2014